Naval Hospital Oak Harbor Prime Health Center
Three Year Well Child Visit

Date:
Time:

Provider Note

Interval History:

Past Medical History:

Medications:
Allergies:
Immunizations:
Family/Social History Update:

Development: ❒ Walks upstairs alternating feet ❒ Balances on each foot 1 second ❒ Names a friend
❒ Speech 75% understandable ❒ 3 word sentences ❒ Puts on T shirt

Physical Exam

Vital Signs ❒ N/A

Weight: _____ kg _____ lb _____%ile
Length: _____cm _____ in _____%ile
Body Mass Index: _____ kg/m^2 _____%ile

Temp: _____
RR: _____
O2 Sat: _____

HR: _____
BP: _____

Pain: ___ (0-10)

Cover/Uncover Test
❒ Nl ❒ Abn

Nl	Abn	
❒	❒	General Appearance:
❒	❒	Head:
❒	❒	Eyes:
❒	❒	ENT:
❒	❒	Neck:
❒	❒	Chest:
❒	❒	Heart:
❒	❒	Abdomen:
❒	❒	Genitals:
❒	❒	Musculoskeletal:
❒	❒	Skin:
❒	❒	Neuro:

Assessment

Plan

Anticipatory Guidance
Immunizations: Influenza
Labs: Microhematocrit
Other:

Follow-up: 4-5 years of age other: _____

Addressograph

_____
Examiner's Signature/Name Stamp

Three Year Well Child Visit
Parent Questionnaire

1. Child's water source: ❒ City ❒ Well ❒ Bottled

2. Do you provide your child healthy food choices and nutritious snacks? Yes/No

3. Have you switched from whole milk to low-fat milk? Yes/No

4. How often do you brush your child's teeth?_____ Seen by a dentist? Yes/No

5. Is your child fully toilet-trained? Yes/No

6. Do you have a routine for putting your child to sleep? Yes/No

7. Do you read to your child? Yes/No

8. Do you try to regulate your child's television-watching (time, content)? Yes/No

9. Does your child play with other children his/her age? Yes/No

10. Are there any smokers in the household? Yes/No

11. Is there is a gun in the home? Yes/No

12. Does your home have working smoke detectors? Yes/No

13. Do you ever leave your child alone in the bathtub? Yes/No

14. Is your child closely supervised at all times (i.e. playground, yard)? Yes/No

15. Have you taught Stranger Safety to your child? Yes/No

16. How is your child restrained when he/she rides in a car?

17. How do you discipline your child?

18. Do you fear for the safety of yourself or members of your family? Yes/No

19. What questions do you have for your child's provider today?